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TO: Nursing Homes NH 003
Hospices HSPCE 003

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Bureau of Quality Assurance

Questions and Answers From the Hospice/Nursing Home InterfaceTraining.

Attached are questions and answers that were developed from the three Interface Workshops that were held in May and June 1996. We combined some of the questions with similar content, and combined the answers to reduce the volume of paper.

Any questions or concerns regarding this memo should be directed to Dick Cooperrider, Supervisor, Community Based Providers (608) 267-7389 or Barbara Woodford, Nurse Consultant, (608) 264-9896.

JF/DC/pd

Hospice/Nursing Home Interface Questions And Answers

1. Q. How are retroactive adjustments to the nursing home room and board managed between the hospice and the nursing home? If the hospice pays a higher rate, will the state also make a positive adjustment, retroactively?

   A. Hospice rates for Medicaid recipients residing in nursing homes do not include retroactive increases or decreases in nursing home rates. Medicaid payments is to the hospice and is not adjusted to reflect a retroactive rate change that the hospice may experience.

   Every hospice with recipients residing in a nursing home must have a contract with that facility to provide services. Rate negotiation for this contract is between the nursing home and the hospice. Wisconsin Medicaid does not dictate rates for the contract nor will the contract rate impact the amount of reimbursement the hospice will receive from Wisconsin Medicaid.

2. Q. If the NH resident is receiving WMA payment for hospice room and board, is the resident responsible for patient liability? (Reference WI Medical Assistance Provider Handbook Part S Hospice – Section 1 – Page 51-001). Part 5 of the provider handbook states that the patient liability is not to be deducted from the hospice claim. Does this mean that the liability should not be collected from the patient. When this happens, the patient's assets will accumulate and they could potentially become ineligible for Medicaid and would have to pay the room and board privately. Is this interpretation correct? Would the patient have to reapply when assets are used up on the room and board?

   A. Refer to pages 1 and 2 in the Wisconsin Medicaid Update 96-43 dated November 20, 1996. It was mailed to all hospices and nursing homes.

3. Q. Can a nursing home have a contract with a hospice and charge the hospice more than 95% of the NH rate. Can they charge for supplies related to the terminal illness? Can a NH charge a hospice rental for the use of DME by the hospice patient in the NH?

   A. Rate negotiation is between the nursing home and hospice. Wisconsin Medicaid does not dictate rates for the contract. If a hospice wishes to reimburse a nursing home greater than 95% of that facility's daily rate, they may certainly do that. That decision, however, will not impact the amount of reimbursement they will receive from Medicaid.

   The nursing home may not bill the hospice for supplies or equipment rental included in the Medicaid nursing home daily rate. The nursing home may bill the hospice for medically necessary supplies or equipment not included in the Medicaid nursing home daily rate.

4. Q. If a MA NH residents enters acute care and is also a hospice patient, does MA reimburse hospice for the MA bedhold? What is the reimbursement?

   A. General inpatient care is not reimbursed for the same date of service as room and board in a NH for the same recipient, so no bedhold is paid to the hospice.

5. Q. Does the Medicaid hospice benefit have 4 benefit periods like the Medicare benefit?

   A. Wisconsin Medicaid does not limit the number of benefit periods to four as Medicare does.

6. Q. Please clarify – families perform dressing changes at home. When would hospice be performing dressing changes in the nursing home?

   A. Direction provided in the State Operations Manual Transmittal 265 dated December 1994, states, "professional management" for a hospice patient who resides in a SNF/NF should have the same meaning to a hospice that it would have if the hospice patient were living in his/her own home. The professional services usually provided by the hospice to the patient in his/her own home should continue to be provided by the hospice to the resident in a SNF, NF, or other place of residence. This includes furnishing any necessary medical services to those patients

that the hospice would normally furnish to patients in their homes. In addition, substantially all hospice core services (physician services, nursing services, medical social services, and counseling) must be routinely provided directly by hospice employees cannot be delegated. The hospice may involve the SNF/NF nursing personnel in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice patient's family/caregiver in implementing the plan of care. For example, SNF/NF staff who are permitted by the facility and by law, may assist in the administration of medication or perform dressing changes as outlined in the plan of care developed by the hospice interdisciplinary group in coordination with the SNF/NF.

7. Q. How extensive can home hospice services be? Are there limits on the amounts of CNA, RN, SW, etc., hours that can be provided in the home, and, if so, what are the limits? For example, can a CNA visit the hours 2 hours, 8 hours or 24 hours a day?

   A. The hospice must make all covered services available on a 24-hour basis to the extent necessary to meet the needs of the individual for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions per 42 federal regulations CFR 418.50(b). However, there are limitations for payment under the Medicare benefit.

8. Q. When a hospice patient appears to fit the "criteria" of incapacitation (so as to activate the patient's power of attorney for health care) who do you believe should initiate the two letters of incapacitation? Hospice SW'er or NF SW'er.

   A. The hospice would assume the responsibility.

9. Q. What amount of social service involvement do you see as appropriate for a palliative hospice patient?

   A. The amount of social service involvement with the hospice patient is based on an assessment of patient/family needs.

10. Q. If hospice contacts a family re: change of condition/intervention, are they required to call the NH and update them on family response to have that documented in nurses notes?

    A. The hospice should update the nursing home staff if the family response would affect the provision of care. Both patient records should reflect this contact.

11. Q. After NH and hospice collaborate regarding the care plan, can this be printed by the nursing home computer as long as all required elements are there?

    A. Yes, as long as the hospice agrees to use the format and all required components are included.

12. Q. We have used "standardized care plans" based on nursing diagnosis which allow for individualization. Is this acceptable format? (in nursing home)

    A. "Standardized care plans" can be used if they are individualized to meet the needs of the patient and family.

13. Q. Can hospice and NH chart on the same narrative note as long as both have a copy in each respective chart?

    A. Yes, this is acceptable.

14. Q. If a resident is receiving hospice services and care is palliative, what diagnostic tests would be getting done?

    A. Diagnostic testing could be done if ordered by the attending physician and authorized by the hospice.

15. Q. If there was a potential cite that was related to a responsibility of hospice, would the NH be cited as a deficiency?

A. No.

16. Q. How would you conduct a survey if the main office is in LaCrosse (Western Region) and a contracted nursing home in Juneau (Southern Region)?

A. The regional office responsible for the LaCrosse location would conduct the survey. The hospice surveyor can cross regional lines when necessary.

17. Q. If physician services are core services, why does the physician order need to be prior authorized by hospice prior to initiation by the nursing home?

A. Hospice has the responsibility for the overall professional management of the patient's care.

18. Q. In presenting a nursing home with medical information, can a hospice legally copy medical information such as H & P obtained from another health care provider or does the provider of origin need to be notified and request such information directly from the provider?

A. Since that information becomes part of the medical record, it can be copied and provided to another health care provider.

19. Q. Residents accepting/choosing hospice have the "right" to choose to be "full code." This seems counter-productive to the hospice philosophy. When/how should this be an option. It poses an impossible goal. This person will die and you must do CPR at that time. How can this be an expectation in a hospice program? This is ethically/philosophically ridiculous.

A. The patient's "right to choose" question has been sent to HCFA for their interpretation.

20. Q. Will hospice surveys be done by the State of Wisconsin on hospices based in Minnesota, but providing care to WI nursing homes (and private home) residents?

A. Yes. Under the Authority of Wisconsin Administrative Code HSS 131 license.

21. Q. If a hospice client enters the hospital for symptom management (i.e., pain out of control), the hospital stay is covered by hospice. The patient then decides to go to SNF after hospitalization. Can the days of hospitalization by used to justify Medicare coverage of SNF? Example: Hospital stay 5/28 to 6/2 covered by hospice. SNF stay 6/2 -–ongoing – can these days be billed to Medicare if Medicare doesn't pay for the hospital stay?

A. Contact your fiscal intermediary for billing and coverage issues.

22. Q. If a patient chooses to revoke the hospice Medicare benefit in order to receive a Part A Medicare coverage in the nursing home, but still chooses to receive hospice services on a private pay basis, who coordinates the plan of care? Does the responsibility for care services change at all?

A. The SNF is responsible for the plan of care. The hospice regulations would prohibit the hospice from serving this patient because they would not have control of the care plan.

23. Q. Did I correctly understand that if a patient (hospice) residing in a nursing home chooses to have room and board covered by Medicare (if eligible), and also continue as a hospice patient (hospice care offered free of charge), the hospice is still responsible for the professional management of the care? If this is not so, how can a hospice work with a nursing home resident who wants hospice care, yet has chosen SNF Medicare benefits?

A. See the above response. The hospice could only be involved as a consultant to the nursing home.

24. Q. In the event of end stage Alzheimer's, the resident stabilizes and hospice benefits are terminated, does a new MDS need to be generated if there is no change in ADL status, no medication change, no change in mental status and no change in nutrition?

A. Yes, patient has a change of condition from a terminal to a nonterminal state.

25. Q. Please speak specifically about provision of core services and what, if any, continuing role the nursing home social worker has following admission of a hospice resident.

A. The nursing home social worker would continue to collaborate with the hospice and provider services as approved by the hospice care team and outlined within the plan of care.

26. Q. Admission with pending guardianship to nursing home; is this the same for hospice?

A. Yes, however the individual who will be appointed guardian should be involved in the admission process and sign the necessary forms.

27. Q. Is it legal, financially for a nursing home to have its own hospice unit within the home? If so, is a separate hospice provider number needed, or is it only possible through an outside independent agency?

A. Yes, a nursing home provider can request to be separately licensed and certified as a hospice provider.

28. Q. Please further explain statement on state and federal law that "a nurse practitioner may be utilized after 30 days of the first 90 days, and after 60 days thereafter." Does this mean the MD does not have to see patient in a nursing home, or does the MD do first visit at 30 days, then at 60 and 90 days, the nurse practitioner can make visits and every 60 days thereafter.

A. In a SNF, the first required visit at 30 days must be made by a physician. The required visit may then be alternated between the physician and a nurse practitioner, a physician assistant or clinical nurse specialist.

29. Q. If an employee of the nursing home is on the hospice team and is providing some of the core services, i.e., nurse. Can they be the one involved with any change and document of RAPS and care plans? Can she do this on the nursing home time or is she to include this as hospice time? Does it matter?

A. The employee must be functioning as an employee of either the nursing home or the hospice; they cannot be functioning as an employee of both providers at the same time.

30. Q. If a nursing home is currently making hospice services available through contracts with hospice providers and the administration finds that too many in-house patients qualify for hospice and this would result in a decrease in payment for the facility, is it legal to discontinue the service even though it isn't in the best interest of the resident.

A. The nursing home does not have to contract for the provision of hospice services. The nursing home may decide to discontinue their contractual relationship with the hospice following the procedures outlined in the contract.

31. Q. What exactly gets waived if you apply for HSS 132 waiver?

A. See the BQC memo #96-025, dated May 2, 1996. All HSS 132 codes are waived except for those identified in the memo series.

32. Q. Do all restraint orders need to be obtained via the hospice nurse?

A. Yes.

33. Q. If the physician who has cared for the resident is unwilling to see them in the nursing home for 60 day visits, activation of POA, etc. what are the options? Whose responsibility is it to explore these options?

A. The hospice medical director has the responsibility to oversee the medical services. The 60-day visit requirement is the responsibility of the nursing home. The nursing home and hospice need to collaborate in obtaining a physician to fulfill this requirement.

34. Q. The hospice has orders for Roxanal 2-6 mgm po q 2 hrs. PRN for pain management. The care plan states give Roxanal 4 mg PO q 2 hrs. on schedule. In a nursing home setting, is it acceptable to give a PRN medication on a schedule?

A. Yes, as long as the medication is administered based on an assessment of the patient's pain management needs.

35. Q. Does the hospice need to approve medications for a hospice patient residing in a nursing home that are not related to the terminal illness?

A. Yes. All services provided as identified in the plan of care are under the direction of the hospice.

36. Q. Is a current history and physical required for a hospice patient entering a nursing home or is this requirement included in the state-wide waiver?

A. A current history and physical are included in the state-wide waiver of HSS 132.

37. Q. Nurse practitioners or physician assistants have nursing home privileges and work with patient's attending physician. How are orders written by the Nurse practitioner or physician assistant managed? Any limits to type of orders?

A. Hospice regulations do not allow nurse practitioners and physician assistants to write orders. Since hospice controls physician services, it would not be allowed based on hospice rule.

38. Q. If hospice staff document a visit in the nursing home's record, the nursing home records are copied for hospice on a regular basis. Does the hospice staff person also need to document the visit in the hospice record?

A. The hospice clinical record must be completely, promptly and accurately documented in accordance with federal regulations 42 CFR 418.74. The intent of this regulation could be met by retaining a copy of the entry made in the nursing home record in the hospice record.

39. Q. If you have a hospice contract, must all residents in the SNF who are in a "terminal state" be given the choice of opting into hospice?

A. This is an individual patient decision that must be made in consultation with the attending physician.

40. Q. If a patient is "admitted" from hospice to a SNF, is the "initial" MDS the first and last MDS or when you have the first significant change of condition?

A. All regulations pertaining to resident assessment in a SNF apply. A significant change in the patient's condition that requires a change in the plan of care would require a new MDS as part of a new comprehensive assessment. The change should be unexpected and not planned for.

41. Q. If a patient qualifies for hospice care, is a facility, whether a hospital or nursing home, obligated under law to advise the patient that this service is an option and available to him?

A. No. The facility needs to address meeting the patient's needs. If the hospice service would best meet the resident's needs, this should be a care planning consideration.

42. Q. I am assuming that only the resident can give consent for admission to a hospice/NH placement, unless they have an activated HCPOA or have a legal guardian with Ch. 55. Is this correct? I am assuming that a family member, significant other, cannot admit a hospice resident without one of the above in place. Who can admit a resident to hospice?

A. A hospice patient can be admitted to a nursing home without a guardian or activated HCPOA if the legal proceedings are in process. However, this applies only to patients being admitted from a hospital.

43. Q. Is it a regulatory requirement that each provider keep a copy of each provider's complete record upon discharge? If so, why?

A. No. It is not necessary to keep a copy of the entire record of each provider. The clinical record maintained by each provider must include complete documentation of all services and events appropriate to the care of the patient for that provider.

44. Q. If there is a hospice client transferred from home to nursing home on "mind altering drugs" such as Ativan or Haldol, is the nursing home required to withhold X days prior to admission?

A. There is no requirement for the medications to be held.

45. Q. If a nursing home has done a significant change assessment and new MDS, RAP, etc., on a resident and the resident is then admitted to hospice, does another MDS, RAP, etc., need to be done if the nursing home has care planned for decline prior to hospice referral or admission?

A. No.

46. Q. If hospice uses a NH facility for a 5-day respite stay, is the MDS necessary?

A. No, because respite is a short term inpatient service. The facility must do an assessment that will result in the necessary resident needs being met.

47. Q. (1) If the resident would qualify as an Intensive Skilled Nursing (ISN) resident, can we charge the ISN Medicaid rate? (2) And if the resident is at an ISN level, do we chart (in the nursing home) on a daily basis? I would believe that the hospice nurse charting could be included in that daily charting.

A. Refer to question #3. The SNF documentation should reflect the care they are giving and that resident needs are being met.

48. Q. Can NH staff take a telephone order from a hospice nurse who has obtained this order either verbal or by telephone from the physician?

A. Yes. The nurse would document receipt of this as a telephone order from the hospice nurse. The hospice would obtain the physician's signature and forward a copy to the nursing home for inclusion in the clinical record.

49. Q. Can a nursing home write in a contract with a hospice (assuming the hospice agrees) that overall management of nursing care for a hospice resident be that of the NH; to be accomplished in collaboration with hospice staff?

A. No. The hospice is required to retain responsibility for the overall management of the services provided to the patient and the family in accordance with the plan of care per Wisconsin Adm. Code HSS 131.35 and federal regulations 42 CFR 418.56(c).

50. Q. Does a nursing home have a legal (or ethical) responsibility to have a contract with a hospice? Can a NH deny this care to a patient because it does not want to work with hospice?

A. A nursing home is not required to have a contract with a hospice. If a patient elects to receive hospice services, they would need to transfer to a nursing home that would be willing to have a contract with the hospice.

51. Q. Is it okay to specify in your policy who is responsible for the disposal of medications if the nursing home wants to follow their policies or does this need to be in the contract as well?

A. Federal regulations at 42 CFR 418.96(b) require that the hospice have a policy for disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient. In addition, the method of disposal should be outlined within the written agreement between the hospice and the nursing home.

52. Q. How do you handle it when a patient goes to a SNF and their medical doctor refuses to continue their care, the NH refuses the services of their MD due to contract issues, and the hospice medical director does not feel comfortable handling their non-terminal diagnosis?

A. If the patient elects hospice services, the hospice medical director must assume the overall responsibility for the medical component of the hospice's patient care program per federal regulations 42 CFR 418.54. The patient should not be admitted to the nursing home until these issues are resolved.